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BUILDING AN AMERICAN HEALTH SYSTEM: JOURNEY TOWARD A HEALTHY AND CARING AMERICA

A REPORT

BY THE

CHAIRMAN

OF THE

SELECT COMMITTEE ON AGING
HOUSE OF REPRESENTATIVES

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PREFACE

Over the past several years, the House Select Committee on Aging has conducted hearings on and examined the arguments for and against various legislative proposals for comprehensive reform of health and long term care in America. One of the many vehicles that can be used to accomplish this is my own national health plan proposal, the "USHealth Act" (H.R. 2980). In the course of our Committee's review, we have tried to assess the potential of these proposals for alleviating the Nation's cost, quality and access problems and for building an American health system.

During the time we have worked on this issue, the call for comprehensive change has grown ever louder. Concern has certainly grown over the failure of the American approach to protect the 31–37 million persons with no insurance and the over 200 million persons with inadequate protection against long term care costs. However, concern over rapidly rising health care costs is the main driving force behind comprehensive reform today.

With prudent and caring leadership, these concerns can power an agenda forward which provides affordable and quality protection to the many millions of uninsured and underinsured Americans. It is my hope that an important part of that leadership will be provided by the Congressionally mandated U.S. Bipartisan Commission on Comprehensive Health Care, also known as the "Pepper" Commission.

As the Member who worked with Claude Pepper on the enabling legislation that established this historic Commission, I strongly believe that the Commission will be held accountable for and must fully discharge its legislated mandates:

> Section 402. "the Commission shall make specific recommendations to the Congress respecting Federal programs, policies and financing needed to assure the availability of (A) comprehensive long term care services for the elderly and disabled, (B) comprehensive health care services for the elderly and disabled, and (C) comprehensive health care services for all individuals in the United States."

That last mandate, to go beyond long term care and beyond the elderly and disabled to address comprehensive health care for all, was specifically added at my request.

As compared to just a few years ago, all of us, including the Commission, are fortunate to have several comprehensive reform options, including those discussed in this report, available for consideration. In choosing among these options, certain criteria should be applied:

- Are the uninsured fully insured?
- Are the underinsured insured for basic health care?
- Are the underinsured insured for catastrophic acute care?

- Are the underinsured insured for catastrophic long term care?
- Is the quality of health care assured for everyone?
- Are costs affordable for individuals, government and employers?
- Is it feasible to implement?
- Will the public support it?

Congress and the Administration cannot meet its responsibility to the American people and the Bipartisan Commission cannot discharge its mandate with anything less than a comprehensive plan. Not just for the poor or the rich or the elderly, it must provide comprehensive protection for all Americans. Not just physician and hospital care, it must provide comprehensive health and long term care. Not just for certain States, it must provide comprehensive nationwide protection.

Though some argue for piece-at-a-time solutions to these problems, Congress should support a comprehensive solution. The Medicare Catastrophic Coverage Act is one example of a piecemeal approach that failed. The failure of either business or government by itself to contain health care costs is another argument against piecemeal approaches.

It is my opinion that we should expand Medicare to provide basic health and long term care benefits for all Americans, regardless of age or income. We should cover primary, acute and long term care with special safeguards for catastrophic illnesses. As a tradeoff to secure this protection, we should set a national health and long term care expenditure cap.

Even in this time of tight budgets, Congress needs to take on this most difficult issue. Our own House Committee on Aging, as well as other committees, has held major hearings documenting two critical access deficiencies. First is the large number of Americans without any health insurance coverage—31-37 million people are uninsured.

The fundamental right of every American to access necessary health care can no longer be denied. We can no longer ignore the 31-37 million fellow Americans lacking insurance for either basic or catastrophic health care.

The second great deficiency is underinsurance, inadequate coverage for primary, acute, and long term care. Young families are more and more likely to be working for employers who provide no or only minimal coverage. Over 200 million Americans are without long term care protection—be it public or private—and are at major risk of financial disaster when hit by a catastrophic, chronic illness.

Americans find it unacceptable that those underinsured for long term care not only face the tragedy of severe long term care illness, but face a second tragedy—a financial disaster striking both young and old. We can no longer ignore our Nation's need for protection from and thus coverage for long term care costs.

As I stated earlier, I believe that a national health plan is best built on the base of the Medicare program and should ensure that all Americans are entitled to basic and catastrophic health insur-

ance as well as comprehensive, flexible, managed and cost-capped long term care coverage.

This Nation needs a comprehensive, national health plan that dismantles existing financial barriers to health care, slows the Nation's escalating health care costs and improves health care quality. Also, the plan should take the unprecedented step of imposing a health and long term care cost cap at 12 or 13 percent of the Gross National Product.

Without such an approach, the Nation's health costs are projected to reach as high as 15 percent of the GNP by the year 2000. Without such an approach and despite this enormous national investment, we would still not have resolved the crisis facing people with catastrophic illness and people without adequate health insurance protection. Setting a national health and long term care expenditure cap is a fair tradeoff to secure comprehensive protection for all Americans.

We should develop a carefully articulated system for providing long term care protection. Long term care expenditures should be capped at 1.1 percent of GNP and managed through a care management system which ensures that beneficiaries receive the care they need and that taxpayers will not face increases in costs beyond increases in their ability to pay. Further, long term care benefits should be flexible to best match beneficiary needs and promote beneficiary independence.

It is important that people be aware of the cost of health care. One way to do that is to require cost sharing of 20 percent of medical and skilled nursing home care and 25 percent of nonskilled long term care. This cost sharing could be capped by the catastrophic limits which are $600 per person per year for medical and skilled nursing care and $1,000 per person per year for nonskilled long term care.

Health care providers should be paid prospectively, e.g., DRGs (Diagnostic Related Groupings) for hospitals and relative value scale fees for physician care. These fees should be developed in consultation with representatives of health care providers and indexed (to increases in per capita GNP) to our Nation's ability to pay.

We need a plan that brings about critically needed improvements without disrupting the essential professional and personal relationship between individual patients and their health care providers. Patient and health care provider "freedom of choice" should be preserved. Patients should be free to continue their relationship with their existing physician or hospital and free to choose among fee-for-service or capitation providers. Health care providers of all types should be included, including public providers and private profit and not-for-profit providers.

Through this plan, we should create a special partnership with the Nation's insurance industry which protects the financial viability of those companies while ensuring comprehensive coverage for every American. It should give the insurance companies a valuable role through contracts for a much larger volume of bill processing and review than under the current system, since the uninsured and recipients of long term care would be covered.

Finally, a national health plan should be totally self-financed through a funding package reflecting much of how we pay for care now. Funding could include:

- the savings generated by indexed prospective payment, capitation, and beneficiary cost-sharing,
- an expanded cigarette tax,
- extension of the Medicare payroll tax to all incomes,
- a premium paid by the elderly (approximating the "Medicare premiums"),
- an employer tax based on compensation,
- State revenues covering one half the cost of the poor, and
- a surcharge on corporate and individual income taxes sufficient for the solvency of the national health plan.

USHealth (H.R. 2980) has all of these provisions and deserves full consideration. I strongly believe that since a broad-based problem exists, only a broad-based solution like **USHealth** will provide the full health and long term care protection which Americans desperately require.

Fortunately, there is no shortage of options for dealing with this broad and tragic problem. It is also important to remember that all options get their funding from the same source, the pockets of the American people, though payment may be made through premiums, out-of-pocket, deferred wages (through employers), or taxes. The criteria for selecting a solution should be solely on what is the most efficient and effective way to use the American people's dollars to meet the American people's health and long term care needs.

Given the forces of change, the burdens of cost, and the inequities of access, the Bipartisan Commission, the 101st Congress and the Bush Administration should make the commitment to fully protect the uninsured and underinsured. The risk to the uninsured and underinsured is great and grows daily. If not controlled soon, health costs will outdistance everyone's ability to pay for needed health care. We no longer can afford not to act. The American people can no longer afford our failure to act.

EDWARD R. ROYBAL,
Chairman.

EXECUTIVE SUMMARY

For many years, the House Select Committee on Aging, under the direction of Chairman Edward R. Roybal, has had a strong interest in comprehensive health and long term care reform. During this time, the House Select Committee on Aging staff analyzed the issues surrounding health and long term care reform and the need for comprehensive reform. The Committee has also held several hearings to examine the critical issues of health care accessibility, affordability and quality as they apply to all Americans. In November, the Committee held its latest hearing which examined the growing consensus for comprehensive, as opposed to piecemeal, reform and examined several of the major comprehensive reform proposals. This report is a result of these hearings and this analysis.

In considering how to address the issues of health and long term care in this country, policymakers must not lose sight of the nature of the problem. Even though some policymakers would like to see health and long term care problems as isolated problems with each being able to be addressed separately, these problems just do not lend themselves to this strategy. Most major health and long term care problems are broad-based. Further, almost without exception, each problem and its solution interacts with other problems and solutions. This is true if we talk about problems with particular geographic areas, patient populations, payers or health care providers.

The temptation is to repeat history and to focus on piecemeal, partial strategies for filling these gaps. However, the lesson of recent history is that many of these gaps exist precisely because we have only done piecemeal, partial reform. Further, history teaches us that piecemeal, partial reform is not done without peril as well.

As we move into the 1990s, a call for comprehensive health care reform is once again moving through this Nation. Within the last year, business and labor have both come before Congress where they have made commitments to improving access and asked for help in controlling costs. Many Members of Congress have put themselves on record in support of comprehensive reform and several have introduced comprehensive health care reform packages.

At the Committee on Aging's November hearing, the statements by the Committee members and the testimony of the witnesses strongly reinforced the message that comprehensive reform should be the highest priority. Further, their views reflect much of what is being communicated through a wide range of public opinion polls. Polls conducted around the time of the 1988 Presidential elections found that 89 percent of respondents stated that "fundamental change" was needed in how U.S. health care worked. Two different polls conducted in 1988 and 1989 documented public support of over 60 percent for an "all-government national health plan" or an

"all-government insurance system such as that in place in Canada."

During the course of the hearing and the Committee staff analysis, a range of comprehensive reform proposals were considered by the hearing witnesses and by Committee staff. In this report, the review focuses on five proposals:

1. The Health Security Partnership Plan,
2. The National Leadership Commission on Health Care Plan,
3. The Basic Health Benefits for All Americans Act (H.R. 1845, Waxman; S. 768, Kennedy),
4. The USHealth Act (H.R. 2980; Roybal), and
5. Canada's National Medicare Plan.

Though each of the above proposals makes a valuable contribution to the debate, they also have some shortcomings. Several proposals do not address long term care at all or only address it as an issue to be developed more fully in the future. Others do not really address quality of care in a comprehensive fashion. Some proposals are either vague or silent on the issue of cost containment.

Each has features that indicate that they are feasible but each has features that indicate potential problems with feasibility. The question of which type of proposal the public will support remains to be settled, but it is clear that the public wants a change from what we are doing now.

It is also clear from the alternative proposals presented at the November hearing that a comprehensive proposal can be developed which meets the eight criteria outlined in this report. To meet these criteria, a solution must protect all Americans for basic and catastrophic health and long term care in a way that keeps costs affordable for all payers and assures health care quality for all patients. Further, the solution must be feasible to implement and supported strongly by the American public.

For further information on national health plan legislation generally or the USHealth Act, contact Gary Christopherson, Yvonne Santa Anna or Carolyn Griffith at the House Select Committee on Aging, Room 712, House Annex 1, Washington, D.C. 20515. Phone: 202-226-3375.

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Introduction

For many years, the House Select Committee on Aging has had a strong interest in comprehensive health and long term care reform. During this time, the Committee has held several hearings to examine the critical issues of health care accessibility, affordability and quality as they apply to all Americans. Most recently, the Committee held a November hearing which examined the growing consensus for comprehensive, as opposed to piecemeal, reform. Further, the hearing also examined several of the major comprehensive reform proposals.

Based on those hearings as well as the thinking of a growing number of public officials, policy experts, consumer groups, and labor and industry, most agree that there is a great and urgent need for comprehensive reform of health and long term care in America. They also agree that the result of that reform should be the extension of protection to all Americans.

This report will review the background on the broad-based problems facing health and long term care in America. It will look at the recent experience with piecemeal reform and the perils of taking that route. The report will then consider the increasing call for and emerging consensus on comprehensive reform.

Given that comprehensive reform is gaining momentum, the report stresses that comprehensive reform proposals are available to policymakers. Several of these comprehensive reform proposals are analyzed in terms of their common elements as well as their differences. As policymakers move forward on choosing a comprehensive reform proposal for this Nation, several criteria need to be met in order to ensure the adequacy of any reform adopted. By meeting these criteria, this Nation would demonstrate that it is committed to avoiding past failures and to protecting all Americans needing health and long term care.

Comprehensive Problem Needing Comprehensive Solution

In considering how to address the issues of health and long term care in this country, policymakers must not lose sight of the nature of the problem. Even though some policymakers would like to see health and long term care problems as isolated problems with each being able to be addressed separately, these problems just do not lend themselves to this strategy. Most major health and long term care problems are broad-based and, almost without exception, each problem and its solution interacts with other problems and solutions. This is true if we are talking about problems with particular geographic areas, patient populations, payers or health care providers.

Consider access as one problem area. Financial access is clearly an issue for those Americans without any insurance. As a group,

these 31–37 million Americans are in deepest need and are the first to come to mind.

However, financial access is also a major issue for the underinsured. The underinsured may be young working families with very limited insurance providing few covered services and/or high co-insurance and deductibles. The underinsured may also be persons at risk or in need of long term care. Over 200 million Americans fall into this category. Though Medicaid ultimately covers the poor and those who spend down into poverty, the loss of dignity is something many Americans have difficulty handling. The elderly and disabled, generally covered by Medicare, are also underinsured for acute care expenses and face purchasing expensive Medigap insurance plans or exposure to high and uncovered out-of-pocket health care costs.

Beyond the issue of insurance, access applies to the physical availability of health and long term care. In rural areas, choices of health care providers are always limited. In poor rural areas or frontier areas, there are few if any choices. For central cities, all types of very sophisticated health care may be only a few miles away, but getting there can be very difficult. Crime and poverty both tend to isolate people and make it difficult for people to leave their central city homes and get to health care providers.

No matter in what geographic area people live, those who are relatively homebound because of physical or mental disability have difficulty getting the health care they need. Home health care provides some care but can be lacking depending upon the insurer's coverage practices, the patient's financial status, the safety of the neighborhood, and the distances between the patient and the provider.

While physical and financial access have continued to be major motivators for policymakers to move forward on policy reform, rapidly rising health care costs have become the primary driver of reform. Rising health care costs are a problem for everyone. They pose a continuing threat to any effort to address the gaps in financial and physical access.

The 1970s and the 1980s were times when health care costs were problems and efforts were made to contain those costs. During the early 1980s, private sector employers and unions made an all out effort to control costs. Early signs of success gave way to failure as health care costs once again rose rapidly. The late 1980s were times when the public and private sectors both started to realize that they were failing to adequately control costs and that another strategy was going to be needed.

For the public sector, the cost containment experience of the 1970s and 1980s was different but no less frustrating. For Medicaid, the rate of increase was slowed down from previous years, but not without serious consequences. During the 1980s, the percentage of the poor covered by Medicaid dropped substantially. For those poor who were able to get on Medicaid, the low payments made by most Medicaid programs often resulted in inappropriately limited access for Medicaid recipients as health care providers chose not to participate in Medicaid.

In the case of Medicare, the Federal Government launched a host of tactics for constraining health care costs. For hospitals,

Medicare set limits on cost-based reimbursement and then moved to prospective payment. Reductions have been made in these latter payments as well. In recent years, annual increases in physician reimbursement were reduced below the increases in the Medicare Economic Index, the standard for adjusting physician payments. For both nursing home and home health care services, the Federal Government put into place administrative controls to deny coverage for services and thus limit access for Medicare beneficiaries.

With all the attention focused on cost and access, relatively little attention had been given to assuring the quality of health care. In recent years, there has been growing attention to a range of approaches for quality assurance within organized settings of care, including hospitals, large group practices, Health Maintenance Organizations and nursing homes. While these efforts are important and should be encouraged to flourish, internal quality assurance programs are generally considered to be insufficient to ensure health care quality for all patients regardless of setting or payer.

Through the 1980s, the most developed external quality assurance effort was being made by the Medicare program. The primary thrust of that quality assurance program was toward hospital care. Early efforts to address problems of nursing home quality were determined to be inadequate in the middle 1980s and led to the latest round of Medicaid and Medicare nursing home reform in 1987. Also in the middle to late 1980s, efforts were begun to address health care quality in other settings. Under Medicare, quality assurance requirements now extend beyond hospitals and nursing homes to Health Maintenance Organizations, clinical laboratories, home health care and ambulatory care, including care provided in physician offices.

Still, major gaps exist. For example, relatively little progress has yet been made in terms of quality assurance in physician office care or home health care. Outside of Medicare, quality assurance is at best sporadic, often depends on cross-over effects from Medicare and Medicaid, misses whole categories of care such as dental care, and generally underprotects major portions of the American public, especially the uninsured.

The Perils of Piecemeal Reform

While it is true that there are major gaps in the American approach to ensuring access, containing costs and assuring quality, the temptation is to repeat history and to focus on piecemeal, partial strategies for filling these gaps. However, the lesson of recent history is that many of these gaps exist precisely because we have only done piecemeal, partial reform. Further, history teaches us that piecemeal, partial reform is not done without peril as well.

Over the past 10 years, business and labor both decided that they would pursue cost containment on their own. For some, the reasoning was that the Federal and State Governments would never get around to protecting their interests and that to wait for public intervention was to do nothing. For others, the reasoning was that the public sector should not regulate costs and that cost containment should be left to the "marketplace." As a result a number of different approaches were attempted by business and labor.

In some communities, large employers or coalitions of employers went to the health care community to bargain for better prices and for help with appropriate utilization control. Other employers and unions installed in-house or contracted managed care operations to examine the health care utilization of their employees and the prices paid by the employer. Some employers, both on their own and because of Federal requirements, tried offering Health Maintenance Organizations in addition to their standard health insurance plans. In some cases, employers developed their own health care system with their own in-house providers.

Though many approaches were tried and several brought about temporary slow-downs in employers' rising health care costs, the long term experience was not encouraging. As employers bargained down health care prices, the pressure grew on providers to decrease the cost of care provided to the medically indigent—a major factor in the prices charged by some hospitals. With respect to the costs to employers, health care costs have again begun to rise rapidly. As a result, the voices of business and labor have started to join in a common chorus. The major business associations, as had labor unions done earlier, gave up on going it alone. In a recent letter to Congress, they stated that "effectively managing health care inflation is a top priority of the business community" and "we . . . earnestly request your (Congress) help in this most difficult task."

Another example of the problems with piecemeal solutions is the experience with the Medicaid program. Most people would agree that Medicaid has funded a tremendous amount of badly needed health care since it was enacted in 1965. However, most would also agree that Medicaid is hardly an exemplary example of how this Nation should fund health care for its people. Over the years, Medicaid has sometimes made progress toward covering America's poor and has sometimes lost ground.

In the early eighties, major cutbacks were made in Medicaid which have never been restored in spite of recent efforts to better cover pregnant women and children and to better protect the community spouses of Medicaid-covered nursing home residents. The bottom line is that Medicaid today covers and for the foreseeable future will cover a substantially smaller portion of the poor than it did in 1979. When it comes time to improve Medicaid, the political viability of such improvements must "depend upon the kindness of strangers," i.e., the politically powerful, since the poor and near poor are not a constituency with real political clout.

However, it is not only business, labor and the Medicaid program that have discovered the perils of piecemeal reform. The debacle over the Medicare Catastrophic Coverage Act is a prime example. What was initially a good-intentioned effort by many to fill in several major gaps in the Medicare program was lost as Congress and the Administration repealed all of the Medicare provisions this November.

Though many lessons can be learned from this experience, a major lesson is that partial reform is not the "easy" alternative to comprehensive reform that it was once thought to be. Over the years, the Medicare program has been surrounded by the purchase of individual Medigap insurance plans, employer-paid retiree

health plans and Medicaid protections for lower income beneficiaries. As a result, any change in Medicare has a major ripple effect with the people covered by these plans. This ripple effect, combined with other forces, came back to ultimately swamp the Medicare Catastrophic Coverage Act.

While the Medicare Catastrophic Coverage Act is one reform approach that failed, it is not the only instance of Medicare-related problems. Just as was the case with the private sector's cost containment strategies, Medicare's cost containment strategies placed pressure on hospitals to protect their financial viability. One response by some hospitals was to reduce hospital bad debt and charity care and thus be able to survive with lower Medicare and private sector payments. Medicare's containment efforts have had some successes but again Medicare has seen hospital cost containment and changing medical practice result in increased nonhospital costs, e.g., the ballooning of outpatient hospital care costs.

Even if there is agreement to do small-scale reform as we have done for the past decade, there are problems, one new and one old. The decade-old problem is the problem of huge Federal budget deficits and the role that the Gramm-Rudman-Hollings Balance Budget Act plays in reducing those deficits. For programs like Medicaid which depend on general tax revenue to fund improvements, expanded Medicaid funding must come as part of a general tax increase or must come from savings in other programs financed by general revenues. Neither approach has been particularly successful for Medicaid in recent years (even though there have been relatively minor Medicaid improvements) nor are they likely to be in the future.

The new problem for smaller scale reform is uncertainty over the continued availability of the primary legislative vehicle for recent reform efforts—the annual budget reconciliation bill. Especially since 1981, most Medicare and Medicaid changes have been included in the annual budget reconciliation bill passed by Congress and signed by the President. During the 1989 budget deliberations, there was a major effort in Congress to strip the budget reconciliation bill down to primarily those provisions which directly contributed to deficit reduction.

In the final few days of the Congressional session, several provisions were accepted which were not "deficit reduction" provisions, including Medicare physician payment reform and expanded Medicaid coverage for pregnant women and children. However, the message from the 1989 session was that future reconciliation bills may not be available for those Medicare and Medicaid changes which do not reduce the Federal budget deficit. Without the budget reconciliation bill as a vehicle for nonbudget-related health care reform, such health care reform would have to be passed as separate bills and would be much more difficult to get passed, especially if additional funding is needed.

As illustrated above, one lesson of recent history is that small-scale reform, especially under the mixed approach (Medicare, Medicaid, private insurance, out-of-pocket) used by the United States, has become increasingly difficult and complicated to do. Long term, small-scale "fixes" often end up being very temporary "fixes." In another situation, a repair in an area like Medicare may create

problems for the private sector or vice versa. For either the public or private sector, raising additional funds is very difficult unless the taxpayer, employee or senior citizen understands and highly values the increased benefit(s). In an era of huge Federal budget deficits, the demands are even greater. Finally, small-scale public reform can succeed only if there are "vehicles," like the budget reconciliation bill, on which to move that reform.

Consensus Call For Comprehensive Reform

Many times in our Nation's history, we have seen a call for and an attempt to bring about comprehensive health care reform. Our earliest experience was in the 1910s and our most recent experience, until now, was in the late 1970s. During the late 1970s, a wide range of comprehensive plans were set before the Nation by Congress, the President and the private sector. These became part of tough, but ultimately unsuccessful, negotiations over the future of health care in America.

As we begin the 1990s, a call for comprehensive health care reform is once again moving through this Nation. Within the last year, business and labor have both come before Congress where they have made commitments to improving access and asked for help in controlling costs. Many Members of Congress have put themselves on record in support of comprehensive reform and several have introduced comprehensive health care reform packages.

At the Committee on Aging's November hearing, the statements by the Committee members and the testimony of the witnesses strongly reinforced the message that comprehensive reform should be the highest priority. Paul Rogers, former Congressman and former Chair of the House Energy and Commerce Subcommittee on Health and the Environment, stressed the need to avoid patchwork solutions. The National Leadership Commission on Health Care, which he cochaired, felt that it has got to be a "systemic approach." He stated that "... we must strengthen the entire health care system and repair all the links that tie the system together." Further, he stated that "To do that requires, I believe, a comprehensive approach...."

Douglas Fraser, Chair of the Committee for a National Health Insurance and former President of the United Auto Workers, echoed those remarks, but with a greater sense of urgency. Fraser charged that "the health delivery system in the United States is in disarray ... in absolute shambles." He stressed the value of various comprehensive proposals "for it increases the possibility that a serious comprehensive approach will be adopted, rather than still another piecemeal, fragmented solution, each and all of which have failed in recent years."

To further demonstrate the increasing breadth of support for comprehensive reform, the Committee also heard similar remarks from Deborah Steelman, former Domestic Policy Adviser to the Bush for President Campaign and Chair of the Department of Health and Human Service Secretary's Advisory Council on Social Security. In her criticism of piecemeal reform, she shared the common view that "marginal change cannot solve problems of access, quality, and cost in American health care in any meaning-

ful way." As for comprehensive reform, she reaffirmed that "comprehensiveness is the key to reform here" and that this need to try to make comprehensive change "is true in terms of eligibility, in terms of coverage, in terms of financing."

Finally, the message from our neighbor country to the north, Canada, added a large dose of both hope and realism with respect to what it takes to enact and maintain a comprehensive health care system. Graham Scott, former Deputy Minister of Health for the Province of Ontario, gave two reasons for caution. First, there are "basic differences between the philosophies that guide our countries." Second, the U.S. must understand that "our (health care) system produces its own problems and you must be able to address them in your system of government."

However, Mr. Scott's political advice spoke to the potential payoffs of developing a comprehensive health care system. In addition to ensuring financial access to all its citizens for a substantially lower percentage of their gross national product, Graham Scott stated that the Canadian Medicare system's "popularity ratings evoke jealousy in the political arena." He further stated that "Support of the model is always above 90 percent and approval of day-to-day management is over 80 percent."

While these attitudes reflected those witnesses testifying at the November 1989 hearing, their views reflect much of what is being communicated through a wide range of public opini n polls. In a review by Dr. Robert Blendon, of Harvard University, of a number of national polls, he notes that the public is sending strong messages. Polls conducted around the time of the 1988 Presidential elections found that 89 percent of respondents stated that "fundamental change" was needed in how U.S. health care worked. Two different polls conducted in 1988 and 1989 documented public support of over 60 percent for an "all-government national health plan" or an "all-government insurance system such as that in place in Canada."

Filling a Vacuum—The Availability of Alternative Comprehensive Plans

The debate about national health reform has extended over nearly three-fourths of a century. Teddy Roosevelt first made national health insurance a campaign issue in the Bull Moose campaign in 1912. Over the years, the issue has been on and off of the governmental and decision agenda. It received consideration from Franklin Delano Roosevelt during the New Deal period. Harry Truman proposed national health insurance in the late 1940s and 1950s. Medicare and Medicaid, health insurance for older persons and the poor, were passed in the mid 1960s. The idea of a more general national health insurance received considerable attention again in the late 1970s.

As we move into the 1990s, there are a number of alternative comprehensive health care reform plans available to policymakers. Those discussed below are not the only national health care reform proposals, but are a sample of various plans which represent very different approaches to reform and have received attention by the Select Committee on Aging.

During the 101st Congress, several national health care reform proposals have surfaced. These proposals include:

- Congressman Roybal's USHealth Program Act—H.R. 2980;
- Senator Kennedy's and Congressman Waxman's Basic Health Benefits for All Americans Act—S. 768 and H.R. 1845;
- The National Leadership Commission on Health Care Proposal;
- The Health Security Partnership Plan; and
- Canada's National Medicare Model.

A comparison of the aforementioned proposals follows with an emphasis on the following questions:

- Who has responsibility for administration of the system?
- How comprehensive is the system in terms of access to care and scope of coverage?
- What will the delivery system look like?
- How will costs be controlled and who will pay?
- How will quality of care be monitored and assured?
- How will the system be financed?

WHO HAS RESPONSIBILITY FOR ADMINISTRATION OF THE SYSTEM?

The USHealth Program Act establishes a Federal program based on Medicare and managed by the USHealth Administration, the current Health Care Financing Administration. It replaces Medicare, Medicaid and private insurance plans. The USHealth Program is independent and off-budget. Most bill processing and review will be provided through contracts with private insurance companies. **The Basic Health Benefits for All Americans Act** is a pluralistic health care system with a private-public partnership (Medicare, Medicaid, and private insurance) to assure care. Employers are required to cover their employees and Medicaid programs are expanded to cover the poor and near poor.

The National Leadership Commission Proposal retains the Medicare program and private insurance. The Federal Government would provide guidelines for the Universal Access (UNAC) program but the program would not be centrally directed as is the Medicare program. **The Health Security Partnership Plan** retains the Medicare program with the remaining people being covered by a State system based within Federal guidelines. Private Insurance would be continued in modified form, and may serve as qualified insurance delivery plans to be selected by employees and those not with an employer through which they may receive benefits. Medicare continues with its payment practices and standards integrated in the Health Security Partnership over time. The **Canadian** national health care system is administered by 10 Provincial governments which operate within the Canadian federal government's guidelines.

HOW COMPREHENSIVE IS THE SYSTEM IN TERMS OF ACCESS TO CARE AND SCOPE OF BENEFITS?

Within the USHealth Program Act financial access is ensured by making every citizen and permanent resident eligible. Enrollment

in the USHealth Program is through the issuance of an account number either at time of birth or when issued a Social Security number.

The basic health and long term care benefits, most of which are covered by Medicare, includes the following: inpatient hospital and inpatient psychiatric hospital services, medical and other health services, comprehensive outpatient rehabilitation facility services, health care services of a medical care access facility, extended care and nursing facility services, skilled home health services, hospice, alcohol and drug abuse rehabilitation, and outpatient mental health services (including community mental health centers and State-authorized services provided by a clinical psychologist, clinical social worker, or psychiatric nurse specialist). In addition to these services, other covered medical and health services include: nurse practitioner and clinical nurse specialist services, EPSDT (for those under age 21), family planning (individuals of child-bearing age), private duty nursing services, physical therapy, occupational therapy, speech-language therapy/pathology, audiology, and other medical or remedial care recognized under State law and specified by the USHealth program. Dental services, (including dentures), and eyeglasses are added before the year 2000 unless total USHealth expenditures would exceed 12 percent of GNP. Prescription drugs are covered with an annual deductible of $100. USHealth also covers physical checkups, health screening, immunizations, health risk reduction, and other preventive services.

Long term care (LTC) benefits are covered for chronically ill individuals (at least 2 age-appropriate ADL's or a similar level of cognitive impairment). Long term care benefits include: care management services, nursing care, services of a homemaker/home health aide, medical social services, medical supplies, physical/occupational/ speech/respiratory/corrective therapy, patient and caregiver education/training/counselling, day health care, respite care (minimum of 120 hours/year if eligible), nursing facility services (as under the current Medicaid program), and limited transportation. Other long term care services, including personal care, may be covered if authorized by the care management agency and if total costs do not exceed expected cost.

The **Basic Health Benefits for All Americans Act** requires all working Americans and their dependents, as well as the uninsured to have basic health insurance. For Americans who are not covered by Medicare and unable to participate in employment based insurance, the legislation establishes a phased-in public Federal/State program to provide subsidized insurance coverage. The required benefits package must include medically necessary hospital care, physician care, diagnostic tests, prenatal care, well-baby care, and a limited mental health benefit. It must also include catastrophic coverage limiting out-of-pocket costs for covered services to $3,000 per family. And, finally the package may not contain exclusions from coverage based on health status or pre-existing conditions. This proposal does not include a long term care benefit package.

The National Leadership Commission's proposal requires all Americans to have basic health insurance, whether obtained privately, publicly or by employer benefit plans. Older Americans would continue to receive Medicare coverage. The National Leader-

ship Commission does not consider it appropriate for it to establish the original national basic benefits package for all Americans. They further assert that the initial package should be set by enabling legislation. However, the Commission recommends that mental health benefits and preventive services, especially prenatal care, be included in this package. They also recommend that once the national benefits package is determined, employers and individuals purchasing their own insurance would be free to supplement it. In addition, States could require that the basic level of benefits be higher for their residents, for both private and program beneficiaries.

The Commission did not specifically address long term care. The Commission believes the urgent problems in long term care should be addressed through the public-private partnership, shared responsibility approach which the Commission proposes for the overall health system.

The **Health Security Partnership Plan** provides universal coverage for all U.S. residents. Residents not covered by other plans would receive coverage by the programs offered in their State. The Medicaid program would be folded into this program. Medicare would continue to cover the elderly and the disabled. The basic benefits package to which all eligible individuals are entitled is comprehensive in nature. Nevertheless, States, employers, insurers, or Taft-Hartley health plans may choose to supplement the basic benefits package, which includes the following: inpatient and outpatient hospital care; inpatient and outpatient physicians' services; inpatient prescription drugs; diagnostic and screening tests; prenatal and well baby care; mental health services; substance abuse treatment programs; rehabilitative services; hospice care; post-hospital skilled nursing facility and home health services.

A beginning long term care program which provides added benefits for those past the age of 65 and the disabled is to be inaugurated in the first phase. Limited institutional care for those requiring primarily custodial services and new personal care services provided at home are to be added in the first phase. In the second and third phases, eligibility is to be extended to those under the age of one, and then to the rest of the population. In phases two and three, the initial Medicare benefits will be expanded both as to age eligibility and length of benefits.

The **Canadian Medicare Model** provides universal access to all legal residents of a province after a short waiting period. Comprehensive coverage includes all medically required services rendered by medical practitioners in hospitals, clinics or doctor's offices. Treatment by nondoctors, including occupational or physical therapists or nurse midwives is covered. Inpatient and outpatient hospital care, prescription drugs, diagnostic and lab tests, mental health care as well as preventive care including pre-natal and well-baby care are also covered. Limited dental care is available in some provinces. In contrast to Canada's well-established acute health care system, the financing and delivery of long term care are in a state of change, with some coverage, but significant variation among the provinces.

WHAT WILL THE DELIVERY SYSTEM LOOK LIKE?

To establish a comparative focal point, the current delivery system in the United States is a mixed model of public and private health care providers with some growth in Health Maintenance Organizations (HMO's) Preferred Provider Organizations (PPO's), Independent Practice Associations (IPA's) and ambulatory care systems. Within the **USHealth Program Act,** the delivery system would continue with a mixed model of public and private health care providers, however HMOs are encouraged and paid at 100 percent of the average area per capita cost. Medical Care Access Facilities (MedCAF) are also part of the delivery system. MedCAF's are facilities which provides ambulatory, emergency, urgent, surgical care, basic inpatient care, radiology and laboratory services within a rural community.

The delivery systems for the **Basic Health Benefits for All Americans Act,** the **National Leadership Commission on Health Care** plan and the **National Leadership Commission on Health Care** proposals are essentially the same as the current delivery system. The **Canadian Medicare Model** used the delivery system that was in place at the time it was enacted.

HOW WILL COST BE CONTROLLED AND WHO WILL PAY?

The **USHealth Program Act** has several cost containment measures. First, the cost containment program covers all services and patients. Second, the cost containment provisions include paying all health care providers prospectively where payments are developed in consultation with providers. Third, future increases are limited to increases in the per capita GNP. Fourth, States may set up alternative payment programs if they choose and can perform as effectively as the Federal program. Fifth, cost sharing of 20 percent for health and skilled long term care, and 25 percent for nonskilled long term care is required, but only up to the specified catastrophic limits. The poor (under 100 percent poverty) and those spending down into poverty are exempt from any cost sharing which prevents access to needed care.

The sixth cost control mechanism is a ceiling on total U.S. health costs of 12 percent of GNP. Under that ceiling is a ceiling on long term care costs set at 1.1 percent of GNP indexed to changes in severity.

The **Basic Health Benefits for All Americans Act** includes co-payments, deductibles and premiums for some beneficiaries. Medicare cost sharing would be the same as currently. For other plans, co-payments, deductibles and premiums could be established at the State's option for individuals between 100 percent and 185 percent of the Federal poverty level. No co-payments, deductibles, or premiums are permitted for individuals under 100 percent of poverty. Co-payments and deductibles, for public plan services for individuals under 100 percent of poverty who receive coverage from an employment-based plan will be paid by the public plan upon application by the individual. For this same group of individuals the public plan will also pick up the employee's share of the premium, if any, for individuals enrolled in employment-based coverage. For those in the public plan, employers will pay 80 percent of the premium,

(average $1,295), except that employers must pay 100 percent of premium for lowest-paid workers, those earning up to 125 percent of minimum wage. Employees will pay 20 percent of the premium, meet a deductible of $250 for individual and $500 for family and pay 20 percent of expenses up to $3,000; above $3,000, the plan provides 100 percent catastrophic coverage.

The plan also includes a cap on out-of-pocket health expenses. States would have the option of imposing an income-related out-of-pocket cap equal to a maximum of 10 percent of income. Co-payments and deductibles for individuals above 185 percent of the poverty line would be set at the same levels as for private, employment-based plans. For the public plan participants, premiums would be set at the actuarial cost of coverage for all enrollees in the public program.

Cost containment measures utilized in the **National Leadership Commission on Health Care** proposal are not specific but involve assigning responsibilities for all parties—providers, patients, employers and employees, payers and insurers, the private and public sector, physicians and other health professionals, and Federal and State governments. The Commission suggests that there is a need to create mechanisms e.g., a State agency, that encourage all parties to carry out their responsibilities. For the UNAC portion of the plan, the Commission endorses a State entity administering the program, complete with the power to negotiate with providers and practitioners to establish the package and payment policies for the program beneficiaries. Furthermore, the Commission approach to cost control would also be linked to its proposal for improving the quality and appropriateness of health care.

A second cost control mechanism the Commission recommends involves the use of three major cost sharing mechanisms. These include: deductibles, co-insurance and co-payments, and shared premiums. Deductibles are designed to offset the payout of the first covered benefit. The Commission recommends that State agencies design their UNAC programs with a flexible deductible system, e.g., no deductible for low income groups and higher deductible for those with higher income. Regarding co-insurance, the Commission recommends that the UNAC program design its co-insurance system more in line with the type of service provided rather than the site of care. As a model, the Commission suggested a co-insurance rate of 20 percent for most services and a rate of 50 percent for outpatient mental health services.

On flat co-payments, the Commission offers two different recommendations. One approach is for State agencies to establish a flat co-payment scheme. To assist poor people in meeting these payments, the Commission recommends that State agencies limit the amount of out-of-pocket costs based on per capita income. Another alternative supported by the Commission, would be to limit out-of-pocket expenses to $1,000 per person and $3,000 per family for the national package of basic services only. Any out-of-pocket expenses would be the responsibility of the individual or the individual's employer insurance plan. These out-of-pocket limits could be cut in half for those under the poverty level. Consistent with the Commission's Principles of Shared Responsibility and Universal Access, those beneficiaries above the 150 percent of the poverty level would

pay a premium, while those below would not. The Commission suggests that cost sharing in the private sector should parallel cost sharing provisions in the UNAC program, i.e., vary by income, for low-income employees.

Cost containment mechanisms in the **Health Security Partnership Plan** requires participation by Federal, State and territorial governments as well as providers of services. Examples of the cost containment mechanisms include: biennial national and State budgets; special Congressional action required for increases in Federal support beyond the growth in the national economy; payments to hospitals and nursing homes on biennially negotiated, prospectively budgeted basis; central control of State funds through a single State organization; payments to insurance companies and others to be on a capitated basis adjusted primarily by age and sex; payments to physicians by relative value schedule; balance billing prohibited for patients in the core program and mandatory assignment required for Medicare beneficiaries; incentives to move to organized group practice plans and provide improved benefits at competitive costs; a National Advisory Commission to address technological assessment and treatment effectiveness; State certification of insurers based on standards relating to cost, efficiency and quality of service; State standards for monitoring lengths of stay, preadmission testing, and other related quality and cost-effectiveness controls.

Several cost containment measures are utilized in the **Canadian Medicare Model.** These cost containment measures are targeted at hospital budgets, physician services and administrative costs. The Provincial governments have implemented two cost controls to limit hospital spending. The first measure is targeting expenditures, or as it is called in Canada, "global budgeting". The Provincial government decides on the funds it will allocate to each hospital for its operating budget, and if the hospital exceeds the budget, the deficit is paid by the Province and subtracted from the hospital's global budget for the following year. The second measure for containing costs involves regulating capital expenditures, including new equipment, new facilities, and renovations. Each Province bases its capital spending decisions on the needs of the aggregate population and attempts to eliminate waste by accurately forecasting the need for hospital beds and health services in the coming year.

Constraining physician services is another method of constraining costs paid by the Provincial governments. The method for determining physicians' fees differs from that of hospitals. Physicians are paid on a fee-for-service plan, rather than by salaries. The relative weights of services in physicians' fee schedules is determined by the Provincial medical association, which then confers with its Provincial governments to determine the percentage increase of the overall fee schedule for each subsequent year. As the sole payer for physicians' services, however, the Provincial governments have the final word on how much to raise fees.

Another cost-saving feature is that administrative costs for insurance are considerably lower in Canada than in the United States (Evans et al., 1989). In Canada, organization and provider reimbursement are the responsibility of the Provincial governments. In

the United States, private insurers incur these costs as well as the advertising and marketing costs of a competitive financing system (EBRI, 1989). For example, the administrative costs of the Canadian health care system were an estimated 0.11 percent of GNP in 1985, or about $15 per person (in U.S. dollars). This contrasts sharply with estimated U.S. administrative costs which amount to 0.66 percent of GNP, or about $106 per person (Evans, 1987).

HOW WILL QUALITY OF CARE BE MONITORED AND CONTROLLED?

In the **USHealth Program Act**, the current Medicare quality assurance system, including Peer Review Organizations (PRO) and hospital and nursing home quality assurance is upgraded to place at least as much emphasis on quality assurance as on cost containment, cover all health care providers and consumers, cover all health services (hospital, physician, nursing home, home health, ambulatory centers), set up a national Council on Quality Assurance, add Consumer Boards to PROs, establish a patient bill of rights and create an ombudsman program. States have the option to develop their own qualified quality assurance system. If States establish their own plan of quality assurance they must provide at least the same level of protection as the Federal plan. Quality assurance is also addressed through Federal HMO qualification.

The **Basic Health Benefits for All Americans Act** assumes the current quality assurance system. Currently, quality assurance is primarily for hospitals and nursing homes and involves virtually no consumer involvement.

The **National Leadership Commission on Health Care Proposal** would greatly increase research on the appropriateness, effectiveness and quality of care and publicize the results to help patients, providers and payers assess treatment. The Commission also proposes a new unifying strategy for an National Quality Improvement Initiative to support and fund research on the appropriateness, effectiveness and quality of care. Such work would involve periodic collective priority setting, coordination, and progress evaluation, while maintaining decentralized activities. Finally, using the stimulating power of existing external review mechanisms of government and the private sector, the results of such work will be integrated into day-to-day clinical practice and into the decision-making processes of health care organizations.

Within the **Health Security Partnership Plan** national standards in partnership with the States will be established and monitored by the State programs to assure protection of quality. Each State and territory will certify insurers, HMOs, PPOs, and similar organizations which meet standards regarding cost, efficiency and quality of service. Each State and territory will be required to establish State standards, prior to biennial approval in the budget, for monitoring lengths of stay, preadmission testing (hospitals), and other related quality and cost effectiveness controls. A National advisory Commission, funded by the Federal Government, will deal with technological assessment and recommendations relating to clinical treatment effectiveness. It will be authorized to meet regularly to make recommendations for possible inclusion of new technological procedures, discontinuance of payments for inefficient or wasteful proce-

dures and other ineffective medical practices, and to develop consensus standards for major clinical treatments.

In the **Canadian Medicare Model** there does not exist a uniform quality assurance system. Each province has its own utilization review protocol which is delegated to physician representatives. In general, care in hospitals is reviewed by peer review committees of hospital physicians. The findings of these peer review committees are used internally and are not publicly released. Physicians are self-regulated by themselves and by the Provincial Colleges of Physicians and Surgeons. Penalties, such as denial of payment, fines, or suspension or termination of using the provincial billing number are employed if a physician is found negligent in his or her practice. The provinces also have fraud detection systems in place which place random telephone calls to patients to verify medically necessary care. The media also seems to play a large role in "policing" quality of care issues within the Canadian Medicare Model.

HOW WILL THE SYSTEM BE FINANCED?

In order to finance the **USHealth Program** and provide an orderly transition from the current system of financing health care, USHealth is financed through several sources. Much of the long term cost of expanding access and reducing costs for all beneficiaries comes from reducing health care cost inflation for all health care providers. Health care costs savings are expanded by holding cost increases down to per capita growth in GNP—approximating the Nation's ability to pay The bill's provisions are financed as follows: the savings generated by indexed prospective payment, capitation, and beneficiary cost-sharing, an expanded cigarette tax, an extension of the Medicare payroll tax to all incomes, a premium paid by the elderly (approximating the "Medicare premiums"), an employer tax based on compensation, State revenues covering one half the cost of the poor, and a surcharge on corporate and individual income taxes sufficient for the solvency of USHealth.

Financing of the **Basic Health Benefits for All Americans Act** builds on the current health care system's mixed model of employer paid plans, Medicare and Medicaid. Employers are required to provide health insurance for their employees and to pay most of the cost. Private regional insurance pools for small businesses are created. Small employers who experience excessive costs from complying with the mandate will be eligible for a Federal subsidy. The Federal Government requires that Medicaid cover the poor and near poor who are uninsured and will match eligible State expenditures for the program at Medicaid matching rates.

The plan proposed by the **National Leadership Commission on Health Care** requires that all Americans have coverage for a national basic package of services. There are several ways they could obtain and finance this coverage. Most Americans would continue to obtain privately-financed coverage as an employment benefit, with the employer contributing most or all of the money for the premium. Any American could also choose to purchase this coverage with personal funds or could supplement the employer-provided coverage with personal funds. Older Americans would continue to receive Medicare coverage.

Everyone else would receive public coverage through the UNAC program The Commission calls for a shared responsibility in financing UNAC. Although Americans with incomes below 150 percent of the poverty level would have their premiums subsidized, they would be responsible for a small share of the costs of their care at the time of service. Employers who do not provide coverage to their employees would be required to pay a fee, which would finance the UNAC program to provide coverage to all uninsured workers and their dependents with incomes above 150 percent of the Federal poverty level. Employers who offer a health plan would be exempt from the fee if their plan provides the following: 1) provides at least the minimum national level of coverage; 2) limits the employee contribution for that coverage to no more than 25 percent of the total premium; and 3) extends coverage to all full-time workers. Employers who do not meet all three minimum standards would pay the full amount of fee on all employees. The employer has the option of providing coverage to part-time workers who work less than 35 hours a week or to pay the fee for these workers, proportional to the hours worked. Special provisions are proposed for new businesses, small businesses, and new employees.

Self-employed persons who do not have health insurance will be required to pay both the employer fee and the individual fees. To relieve the burden on this group of workers, the Commission proposes to reduce the combined fee by the same proportion that the social security FICA rate is reduced for self-employed persons (FICA for self-employed persons is about 86.7 percent of the combined employer/employee payment for wage and salary workers).

In keeping with the dual Commission principles of shared responsibility and individual responsibility, the plan also calls for a fee to be paid by individuals who do not have employer-sponsored insurance. This individual fee would be levied on all uninsured individuals with incomes over 150 percent of the Federal poverty threshold. These individuals would, in turn, receive coverage under the UNAC program. The fee encourages individuals who have the opportunity to accept coverage from other sources to do so by exempting all covered persons from paying this fee.

The UNAC program would also provide health insurance coverage to all nonworkers and all workers and their dependents with incomes below 150 percent of the Federal poverty level. All current Medicaid participants would be covered under UNAC. Health benefits provided to these individuals would be financed with: 1) State and Federal revenues that would have been expended under the current Medicaid program; and 2) an assessment on employers and individuals above 150 percent of the poverty level known as the Y health premium.

Within the **Health Security Partnership Plan,** new revenue sources include payroll taxes on employers and employees, an employer tax based on compensation, increased private insurance premiums, alcohol and tobacco taxes, and other revenue sources the States may elect. Medicare will continue as a program for the foreseeable future and private, employer-based insurance will cover the employed. Substantial economies are expected through the reduction of waste in the delivery of services, ineffective treatment methods, and gradual decrease in administrative costs. It is expect-

ed that after the initial years of organization and inclusion of beneficiaries now without protection, the annual Federal and State cost increases will not exceed growth in the national economy. The national Health Security Partnership trust funds will be separate from the Federal budget. Income and expenditures are expected to balance each year.

The **Canadian** federal and provincial governments share the financing of health care. The federal share comes primarily from income taxes, as does the provincial share. In all provinces, general tax revenues support most or all of the costs of hospital and physician care.

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Criteria for Choice

Given that we have comprehensive reform proposals on the table and assuming that we have a consensus that our Nation's health care problem is comprehensive and a solution should be of similar scope, what criteria do we then use to make a rational choice?

In the first place, there are some general criteria that can and, in our opinion, should be applied to any seriously considered proposal. The major criteria include:

1. Are the uninsured fully insured?
2. Are the underinsured insured for basic health care?
3. Are the underinsured insured for catastrophic acute care?
4. Are the underinsured insured for catastrophic long term care?
5. Is the quality of health care assured for everyone?
6. Are costs affordable for individuals, government and employers?
7. Is it feasible to implement?
8. Will the public support it?

For any proposal to solve the problem, one criterion is that the uninsured should be fully insured. Today in America there are 31-37 million people without insurance. Some are unemployed and some are employed. Most are under the age of 65. Most have lower incomes. This criteria is met if all the uninsured are protected for both acute and long term care.

A second criterion has to do with those who are underinsured for basic health care. Those who have some insurance but are underinsured for basic health care are often those who are self-employed for whom health insurance is more expensive and difficult to obtain. They may also be part-time or full-time workers for businesses providing only limited coverage. Either of these groups may have coverage for only hospital care or may have coverage with large co-insurance. A comprehensive reform proposal meets this criterion if this group of people is covered for the full range of appropriate health care services and the co-insurance is not overly burdensome.

A third criterion has to do with those who are underinsured for catastrophic acute care. This is the type of problem toward which the Medicare Catastrophic Coverage Act was targeted, although that bill only applied to Medicare beneficiaries. Several studies have shown that many Americans have insurance that stops short of protecting them against the major acute illness requiring major surgery, a long hospital stay or a combination of acute care needs. Their vulnerability comes from being hit with tens of thousands of dollars in medical bills over a short period of time. For those with limited incomes, whether young or old, they have very little ability to cover this kind of huge cost. To meet this criteria, a proposal has to limit the total dollar exposure of individuals and families and must have some sensitivity to people's differing ability to pay for health care.

The previous three criteria have tended to focus more on acute care than long term care. A fourth criterion focuses on long term care. No comprehensive reform proposal fully solves the problem unless it addresses the financial risk of and access to long term care. While acute care, either basic or catastrophic, is of relatively short time duration, long term care, by definition, places a burden on individuals and families for an extended period of time. Long term care drains both the financial and emotional resources of people but more slowly. Further, long term care is often a different

level of care, more supportive care than medical care. While almost 90 percent of Americans have some acute care insurance coverage, almost 100 percent (except for Medicaid for the poor or impoverished) have no long term care insurance coverage. Meeting this criterion means that a comprehensive reform proposal protects people against the impoverishment of long term care and ensures financial access to a flexible package of long term care services.

Beyond the issues of coverage and eligibility is the issue of the quality of health and long term care that people receive. A fifth criterion is that the quality of the health and long term people receive should be assured. In other words, people who need care should have confidence that the person they are receiving care from is qualified, the facility (e.g., a hospital, surgical center or nursing home) meets acceptable standards, and the care meets the standards of the respective health profession and is consistent with the best available research in the respective field. Today, most quality assurance that is done is done internally by the respective health care provider. For Medicare and Medicaid beneficiaries, external quality assurance programs are operated under the auspices of Federal and State agencies. For people with no public or private insurance and people with private insurance, very little external quality assurance is done. In order to meet the fifth criterion, both internal and quality assurance programs should apply to all patients regardless of who pays, who provides the care or where the care is provided.

A sixth criterion has to do with the affordability of health and long term care. Though there is interaction between this criterion and the previous eligibility and service coverage criteria, this criterion is targeted at short and long term affordability for all payers. Under the current U.S. approach, health care costs are rising rapidly for almost all payers whether they be uninsured individuals, Medicare beneficiaries, underinsured individuals, employers, State governments or the Federal Government. Most solutions to date have focused on a particular payer trying to control that payer's costs. One exception to the single payer strategy has been the action by several States to control hospital rates on a State-wide basis for all payers. Other than that exception, Medicaid and Medicare have each done their own cost containment programs as have a number of larger employers.

Also, the history of cost containment supports the view that cost containment should be done carefully so that it does not result in denied access to necessary services or place unreasonable strains on health care providers. In the case of Medicaid, some States pay health care providers at such low rates as to effectively deny Medicaid beneficiaries access to mainstream health care. As for Medicare in the 1980s, home health and skilled nursing facility service coverage were being inappropriately denied just when beneficiaries were being asked to leave hospitals sooner and had a greater need for post-hospital care. With respect to quality, experience indicates that quality is far from uniform and quality is not always up to the standards set by the health care professions. Further, experience also shows that when cost containment is too stringent, quality of care will suffer.

The lack of a consolidated strategy has meant that total national health care costs and individual payer costs continue to rise rapidly, a larger and larger percentage of personal income is going for health care, access to mainstream health care for Medicaid recipients is in question, the quality of care is a growing area of concern, and the medically indigent are getting squeezed out of the health care system. As a result, satisfying the sixth criterion requires that comprehensive health care reform include comprehensive cost containment administered in a way that does not limit people's access to needed and good quality health and long term care.

A seventh criterion deals with feasibility of implementation. Most likely, this rules out a comprehensive approach which is totally outside the experience of the United States or runs contrary to the experience this Nation has had to date. This also supports the idea that whatever we do will be built upon the foundations of what already exists in this country though it could incorporate some successful concepts from other nations. To meet this seventh criterion, a comprehensive reform proposal has to be credible, i.e., there must be very good reason to believe that it could be implemented effectively in this country.

An eighth and final criterion addresses the issue of public support. The lesson of the Medicare Catastrophic Coverage Act is that a program without public support cannot survive when it gets into difficulty. The lesson of the Canadian health care system is that a program with strong public support can weather a wide range of challenges and difficulties. As a consequence, meeting the eighth criterion means that a comprehensive reform proposal has to demonstrate that it is consistent with the American public's views on what American health care should be and that it is likely to attract broad public support.

Even looking at some of the proposals described in the previous section, there are some shortcomings. Many proposals do not address long term care at all or only address it as an issue to be developed more fully in the future. Others do not really address quality in a comprehensive fashion. Some proposals are either vague or silent on the issue of cost containment. As for feasibility, each has features that indicate that they are feasible but each has features that indicate potential problems with feasibility. The question of what the public will support is still up in the air, but it is clear that the public wants a change from what we are doing now. It is also clear from the alternative proposals presented at the November hearing that a comprehensive proposal can be developed which meets these eight criteria.

Conclusion

Over the past 70 years, this Nation has searched for a better way to provide health protection for its people. Though there have been several serious attempts at comprehensive reform, all have fallen short for one reason or another. Twenty-five years ago, the Federal Government took a major step forward in the enactment of the Medicare and Medicaid programs. Both have made major contributions to making health care available to some of our Nation's more vulnerable citizens. Unfortunately, neither has fully protected its

own beneficiaries and both combined have not filled the gaps left by employer-sponsored insurance.

Comprehensive reform has been needed for over 70 years and comprehensive reform is what is needed now and for the future. The breadth of the remaining gaps and weak spots in the health care safety net clearly push us toward major reform and toward comprehensive reform.

What used to be a comfortable alternative—piece-at-a-time reform—is proving not to be so comfortable any more. The enactment and subsequent repeal of the Medicare Catastrophic Coverage Act have taught us that. The failure of cost containment to work fairly and effectively has done the same. The perils of piecemeal reform are now of similar magnitude to the "perceived" perils of comprehensive reform.

Moving into the 1990s, we now have a stronger set of comprehensive reform proposals than we have had in the past. The experiences of the past 10 years have added much to our knowledge base. Further, policymakers are less wedded to their own particular solution and more committed to putting into place a solution.

Which is the best approach? Much of this will depend upon what tradeoffs policymakers are willing to make. While choosing a solution will not be easy, several considerations need to be kept in mind. It is important to remember that all of the alternatives get their funding, regardless of how the money flows, from the same source, the pockets of the American people. As a consequence, selecting a solution should be solely on what is the most efficient and effective way to use the American people's dollars to meet the American people's health and long term care needs.

Other criteria, as noted earlier, need to be applied if the solution is really to be a complete and comprehensive solution. To meet this test, a solution must protect all Americans for basic and catastrophic health and long term care in a way that keeps costs affordable for all payers and assures health care quality for all patients. Further, the solution must be feasible to implement and supported strongly by the American public.

Though we as a Nation have yet to make our choice for a U.S. solution for health and long term care, the American public and policymakers have made themselves increasingly clear. A solution is needed urgently and its scope must be comprehensive. With good alternative solutions now on the policy table, we have run out of excuses for not acting and we are rapidly running out of time.

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